REQUEST FOR INTRA-STATE ASSISTANCE

Please complete the following information. Incomplete/missing information will delay response.

RECEIVING AGENCY:	**SENDING AGENCY:**
ADDRESS:	**SENDING PRIMARY WORKER:**
ATTENTION:	**PRIMARY WORKER PHONE:**
	PRIMARY WORKER EMAIL:

ATTACHMENTS

- ☐ **COURT ORDER**
- ☐ **COURT REPORT**
- ☐ **CASE PLAN**
- ☐ **SAFETY ASSESSMENTS**
- ☐ **SOCIAL SUMMARY**
- ☐ **SUBSTANCE ABUSE EVAL**
- ☐ **MENTAL HEALTH/ PSYCHOLOGICAL ASSESSMENTS**
- ☐ **IEP**
- ☐ **OTHER**

SECTION 1: REQUEST TYPE
(SELECT ALL THAT APPLY)

- ☐ **COURTESY HOME VISTS**
- ☐ **FOSTER HOME, HOME STUDY**
- ☐ **RELATIVE HOME STUDY**
- ☐ **ADOPTIVE HOME STUDY**
- ☐ **FOSTER PLACEMENT (HIGHER LEVEL OF CARE)**
- ☐ **FOSTER PLACEMENT (NON-KIN OR FICTIVE KIN)**
- ☐ **COORDINATE LOCAL SERVICE DELIVERY**
- ☐ **SUPERVISE FAMILY VISITS**
- ☐ **OTHER: _____**

HIGH PRIORITY REQUEST
EXPLAIN (PLEASE ATTACH ALL RELEVANT DOCUMENTS)

NEXT COURT DATE CONCERNING THIS REQUEST:

SECTION 2: FAMILY AND CASE INFORMATION

CASE NAME

UNITY CASE # **ICWA APPLICABLE ☐ Y ☐ N**

IF CASE IS APPLICABLE FOR THE INDIAN CHILD WELFARE ACT PLEASE PROVIDE THE FOLLOWING INFORMATION:

TRIBAL AFFILIATION: TRIBAL SOCIAL WORKER: TRIBAL SOCIAL WORKER TELEPHONE # TRIBAL CONTACT ADDRESS:	HAS TRIBE BEEN NOTIFIED OF CUSTODY? ☐ Y ☐ N TRIBE NOTIFIED OF PLACEMENT CHANGE? ☐ Y ☐ N TRIBAL MEMBERSHIP CONFIRMED? ☐ Y ☐ N IS PROPOSE PLACEMENT ICWA COMPLIANT? ☐ Y ☐ N
	WHAT SERVICES ARE PROVIDED TO MAINTAIN CULTURAL CONNECTION?

MOTHER'S INFORMATION

MOTHER'S NAME: PHONE: LAST KNOWN ADDRESS:	TERMINATION OF PARENTAL RIGHTS: ☐ Y ☐ N DATE OF TPR ☐ Y ☐ N VISITATION PLAN/AGREEMENT ESTABLISHED ☐ Y ☐ N (IF YES PLEASE EXPLAIN)

FATHER'S INFORMATION

FATHER'S NAME: PHONE: LAST KNOWN ADDRESS:	TERMINATION OF PARENTAL RIGHTS: ☐ Y ☐ N DATE OF TPR ☐ Y ☐ N VISITATION PLAN/AGREEMENT ESTABLISHED ☐ Y ☐ N (IF YES PLEASE EXPLAIN)

REMOVAL CAREGIVERS (IF NOT PARENTS) **RELATIONSHIP TO CHILD(REN)**_____

NAME: PHONE: LAST KNOWN ADDRESS:	VISITATION PLAN/AGREEMENT ESTABLISHED ☐ Y ☐N (IF YES PLEASE EXPLAIN)

REMOVAL CAREGIVERS (IF NOT PARENTS) **RELATIONSHIP TO CHIL(REN)**_____

NAME: PHONE: LAST KNOWN ADDRESS:	VISITATION PLAN/AGREEMENT ESTABLISHED ☐ Y ☐N (IF YES PLEASE EXPLAIN)

SECTION 3: CHILD AND PLACEMENT INFORMATION (attach more sheets if necessary)

ARE ALL CHILDREN TO BE PLACED AT THE SAME LOCATION? ☐ YES ☐ NO
(if yes, placement information only needs to be completed for the first child)

CHILD NAME: **UNITY PERSON #** **PERMANENCY GOAL** **DATE OF MOST RECENT REMOVAL**	**DOB:** **☐ MALE ☐ FEMALE** **IEP ☐ Y ☐ N** **LEGAL STATUS**
CURRENT SERVICES (i.e. mental health, substance abuse treatment, PSR, BST etc.)	
NON-COVERED SERVICES:	ANTICIPATED COST:
SPECIAL NEEDS (i.e. pregnant, medically fragile etc)	

PROPOSED PLACEMENT DATE				PROPOSED PLACEMENT ADDRESS			
NAME (CAREGIVER)				NAME (2ND CAREGIVER)			
DOB		SSN		DOB		SSN	
RELATIONSHIP TO CHILD				RELATIONSHIP TO CHILD			
WORK#		CELL#		WORK#		CELL#	
BEST TIME TO CONTACT EMPLOYER :				BEST TIME TO CONTACT EMPLOYER:			

OTHER ADULTS IN HOME (OVER 18)	DOB	SSN	RELATIONSHIP TO CHILD

PROPOSED PLACMENT DURATION:	
APPROVED	**DENIED**

PLEASE EXPLAIN RATIONALE FOR DENIED PLACEMENT

CHILD NAME: **UNITY PERSON #** **PERMANENCY GOAL** **DATE OF MOST RECENT REMOVAL**	**DOB:** ☐ **MALE** ☐ **FEMALE** **IEP** ☐ **Y** ☐ **N** **LEGAL STATUS**
CURRENT SERVICES (i.e. mental health, substance abuse treatment, PSR, BST etc.)	
NON-COVERED SERVICES:	ANTICIPATED COST:
SPECIAL NEEDS (i.e. pregnant, medically fragile etc.)	

PROPOSED PLACEMENT DATE			PROPOSED PLACEMENT ADDRESS		
NAME (CAREGIVER)			NAME (2ND CAREGIVER)		
DOB	SSN		DOB	SSN	
RELATIONSHIP TO CHILD			RELATIONSHIP TO CHILD		
WORK#	CELL#		WORK#	CELL#	
BEST TIME TO CONTACT EMPLOYER :			BEST TIME TO CONTACT EMPLOYER:		

OTHER ADULTS IN HOME (OVER 18)	DOB	SSN	RELATIONSHIP TO CHILD

PROPOSED PLACMENT DURATION:	
APPROVED	**DENIED**

PLEASE EXPLAIN RATIONALE FOR DENIED PLACEMENT

CHILD NAME: **UNITY PERSON #** **PERMANENCY GOAL** **DATE OF MOST RECENT REMOVAL**	**DOB:** ☐ **MALE** ☐ **FEMALE** **IEP** ☐ **Y** ☐ **N** **LEGAL STATUS**
CURRENT SERVICES (i.e. mental health, substance abuse treatment, PSR, BST etc.)	
NON-COVERED SERVICES:	ANTICIPATED COST:
SPECIAL NEEDS (i.e. pregnant, medically fragile etc.)	

PROPOSED PLACEMENT DATE				PROPOSED PLACEMENT ADDRESS			
NAME (CAREGIVER)				NAME (2ND CAREGIVER)			
DOB		SSN		DOB		SSN	
RELATIONSHIP TO CHILD				RELATIONSHIP TO CHILD			
WORK#		CELL#		WORK#		CELL#	
BEST TIME TO CONTACT EMPLOYER :				BEST TIME TO CONTACT EMPLOYER:			

OTHER ADULTS IN HOME (OVER 18)	DOB	SSN	RELATIONSHIP TO CHILD

PROPOSED PLACMENT DURATION:	
APPROVED	**DENIED**

PLEASE EXPLAIN RATIONALE FOR DENIED PLACEMENT

SECTION 4: ASSISTANCE APPROVED
DESCRIPTION OF SERVICES TO BE PROVIDED BY RECEIVING AGENCY
(CHECK ALL THAT APPLY)

- ☐ **COURTESY HOME VISTS**
- ☐ **FOSTER HOME, HOME STUDY**
- ☐ **RELATIVE HOME STUDY**
- ☐ **ADOPTIVE HOME STUDY**
- ☐ **FOSTER PLACEMENT (HIGHER LEVEL OF CARE)**
- ☐ **FOSTER PLACEMENT (NON-KIN OR FICTIVE KIN)**
- ☐ **COORDINATE LOCAL SERVICE DELIVERY**
- ☐ **SUPERVISE FAMILY VISITS**
- ☐ **OTHER: _____**

CONTACT INFORMATION OF ASSIGNED COURTESY WORKER:

NAME **TELEPHONE** **EMAIL**	**SUPERVISOR'S NAME** **SUPERVISOR'S EMAIL**

APPROVING PARTY SIGNATURE:

NAME: **TITLE:**	**SIGNATURE:** **DATE:**